MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15254 15258

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and the nearest town): Rising Sun
c. LENGTH OF STAY IN 1b: 2 months

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Penn. b. COUNTY: Chester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham Rural
d. STREET ADDRESS: R.F.D.#1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 20 Mont St.

3. NAME OF DECEASED (Type or print): First RACHEL Middle WARD Last ARNOLD
4. DATE OF DEATH: Month November Day 19 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Sept.30,1885
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Ward
14. MOTHER'S MAIDEN NAME: Sarah Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mrs. Victoria Cathers Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Arteriosclerotic Cardiosclerosis (Vascular Disease)
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from ____, 19__, to ____, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at 7 A.M., from causes and on the date stated above.

22a. SIGNATURE: Ernest W. Seiter M.D — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: Nov 22 1967
22c. PHYSICIAN'S NAME (Type): Ernest W. Seiter, M.D.D
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov.22,'67
23c. NAME OF CEMETERY OR CREMATORY: Friends Cemetery
23d. LOCATION (City or Town) (County) (State): Calvert Cecil Md.

24. FUNERAL DIRECTOR: C. McMullen
ADDRESS: 20 Cherry St. Rising Sun, Md
25a. REC'D BY REGISTRAR DATE: NOV 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

2

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15255 15259

1. PLACE OF DEATH
a. COUNTY: CECIL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rehobeth Beach
d. STREET ADDRESS: 337A R.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle Robert Lost BECKETT

4. DATE OF DEATH: Month 11 Day 5 Year 1967

5. SEX: MALE

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Jan. 26, 1918 ?

9. AGE (In years last birthday): 49 ? yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron Worker

10b. KIND OF BUSINESS OR INDUSTRY: General Construction

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Beckett

14. MOTHER'S MAIDEN NAME: Mary Gunning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 221-01-0483

17. INFORMANT: James R. Beckett, Jr. (Same as 2 above) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DIABETIC COMA
DUE TO
260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): TOOK SICK AT HOME

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m.: 12 Noon 11/5/67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): AT HOME

20f. (City or town) ELKTON (County) CECIL (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Henry V. Davis M.D.

EXAMINER'S NAME (Type): HENRY V. DAVIS

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 11/6/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Hickory Grove Cemetery

23d. LOCATION (City or Town) (County) (State): New Castle County, Del.

24. FUNERAL DIRECTOR ADDRESS: Edward F. Fellows, Millington, Maryland

25a. RECD BY REGISTRAR DATE: NOV 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15256

CERTIFICATE OF DEATH

15260

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: 263 E. MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JACOB — Middle: T. — Last: BIDDLE

4. DATE OF DEATH: Month: NOVEMBER — Day: 9 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 15, 1884

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOUNDRY

10b. KIND OF BUSINESS OR INDUSTRY: IRON

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: JACOB M. BIDDLE

14. MOTHER'S MAIDEN NAME: ELIZABETH JONES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 159-01-6169

17. INFORMANT: MARGARET P. BIDDLE — Address: ELKTON, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~CARCINOMA OF PROSTATE~~ URAEMIA — INTERVAL BETWEEN ONSET AND DEATH: ~~6 YEARS~~
DUE TO (b): URINARY OBSTRUCTION PARTIAL — 2 YEARS
DUE TO (c): CARCINOMA OF PROSTATE — 6 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to Nov. 9, 1967, that (I) (we) last saw the deceased alive on Nov. 9, 1967 and that death occurred at 11:35 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/9/67

22c. PHYSICIAN'S NAME (Type): HENRY V. DAVIS M.D.

22d. ADDRESS: CHESAPEAKE CITY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Nov. 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: ELKTON CEMETERY

23d. LOCATION (City or Town) (County) (State): ELKTON, CECIL, Md.

24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS: ELKTON Md.

25a. REC'D BY REGISTRAR DATE: NOV 14 1967

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1

15257

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15261

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): UNION Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: 112 DECKER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EDITH	LYDIA	BOND	Nov.	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		MAY 30, 1893	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY
HOUSEWIFE	At HOME	FRAZER, PA.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CHARLES BAILEY	MARY S. MILLER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	215-48-8356	MARGARET WALLACE, COATESVILLE, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia with Abscess formation in kidney — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Metastatic Carcinoma to kidney & Adrenal — 2 months
DUE TO (c): Carcinoma of Colon — 6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/2, 1967, to 11/19, 1967, that (I) (we) last saw the deceased alive on 11/19 1967, and that death occurred at 11:50 M, from causes and on the date stated above.

22a. SIGNATURE: Rolando A. Najera M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/20/67
22c. PHYSICIAN'S NAME (Type): ROLAND A. NAJERA
22d. ADDRESS: E. Main St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11-22-67	GROVE METH.	WHITELAND TWP. CHESTER Co. PA

24. FUNERAL DIRECTOR: Thomas Dee PIPPIN F.H. — ADDRESS: ELKTON, Md

25a. REC'D BY REGISTRAR DATE: NOV 21 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

15256

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15262

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
d. STREET ADDRESS: State Route #161 (Darlington Rd.) Rte.1, Box 19
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MELVIN — Middle HENRY — Last BOWER

4. DATE OF DEATH: Month November — Day 29, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 7-20-16

9. AGE (In years last birthday) 51 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Trucking Business

11. BIRTHPLACE (State or foreign country): Harford Co, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Melvin Bower

14. MOTHER'S MAIDEN NAME: Lettie Margaret Epperley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW 2

16. SOCIAL SECURITY NO. 218-07-6069

17. INFORMANT (Type) Mrs. Mishie M. Bower (Wife) 457-4223 — Address: RD#1, Box#19 Darlington, Maryland 21034

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac tamponade — INTERVAL BETWEEN ONSET AND DEATH
451A
DUE TO
(b) Ruptured dissecting aneurysm of ascending aorta
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]
Address (Street, city, town, or county)

22. DATE SIGNED: November 30, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 2, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Co, Md. 21014

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. RECD BY REGISTRAR DATE: DEC 4 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15259 — 15263

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Dist. of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 720 Otis Place, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emmett — Middle: Thomas — Last: Cheeks

4. DATE OF DEATH: Month: November — Day: 5 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-30-12

9. AGE (In years last birthday): 54 yrs

IF UNDER 1 YEAR: Months: — Days: — **IF UNDER 24 HRS**: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Apartment House

11. BIRTHPLACE (County & State, or foreign country): W ashington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Cheeks

14. MOTHER'S MAIDEN NAME: Elizabeth Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 174-10-9002

17. INFORMANT Address: VA Hospital Records, Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinomatosis with massive ascites
DUE TO
(b): Cancer of stomach w/widespread metastasis
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
151X
INTERVAL BETWEEN ONSET AND DEATH: months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I ~~XXXXXXXXXX~~ VA attended the deceased from October 16, 1967, to November 5, 1967, ~~XXXXXXXXXX~~ and that death occurred at 6:15 pM, from causes and on the date stated above.

22a. SIGNATURE: a. L. Mooney — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 11-7-67

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.

22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/9/67

23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park

23d. LOCATION (City or Town) (County) (State): Maryland

24. FUNERAL DIRECTOR: Stewart Funeral Home, Washington, DC — Spenning Road, NE

25a. RECD. BY REGISTRAR DATE: NOV 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15260 — 15764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1 day

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Veterans Administration Hospital
d. STREET ADDRESS: 418 Ford Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: EARL — Middle: T. — Last: CRESMER
4 DATE OF DEATH: Month: November — Day: 14 — Year: 1967

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 11-10-07
9 AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Storekeeper retired
10b KIND OF BUSINESS OR INDUSTRY: U.S. Govt. APG.
11. BIRTHPLACE (County & State or foreign country): Bel Air, Md.
12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: Harry M. Cresmer (D)
14. MOTHER'S MAIDEN NAME: Sarah Matthews (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 212-03-7012
17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage, Right Side, Massive — INTERVAL BETWEEN ONSET AND DEATH: 6-8-hrs
331 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis — years
DUE TO (c): Arteriosclerosis, generalized, severe — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 14, 19 67 to Nov. 14, 19 67, that (I) (we) last xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx and that death occurred at 12:50 pm, from causes and on the date stated above

22a SIGNATURE: A. L. Mooney M.D — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 14 November 1967
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY
22d. ADDRESS: VA Hospital, Perry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 17 Nov 1967
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery
23d LOCATION (City or Town) (County) (State): Havre de Grace, Maryland

24. FUNERAL DIRECTOR: Tarring Funeral Home, Aberdeen, Md.
ADDRESS: Kenneth B. Tarring
25a REC'D BY REGISTRAR DATE: NOV 17 1967
25b REG STRAR'S SIGNATURE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15261

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Elkton
c LENGTH OF STAY IN 1b: 28 hrs.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a STATE: Md. — b COUNTY: Cecil
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — Elkton
d STREET ADDRESS: R.D. #3, Box 97
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Donald — Middle: LeRoy — Last: Crouch
4 DATE OF DEATH: Month: 11 — Day: 20 — Year: 1967
5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8 DATE OF BIRTH: 8-6-31
9 AGE (In years last birthday): 36 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY: Chemical
11 BIRTHPLACE (State or foreign country): Pa.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: John Crouch
14 MOTHER'S MAIDEN NAME: Margaret Finn

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): Korea
16 SOCIAL SECURITY NO: 171-26-5460
17 INFORMANT: John A. Crouch, Elkton, Md. — Address: R.D. 3

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Internal Injuries
DUE TO
(b): Automobile Accident
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 1½ days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): In Auto Accident (Collision with another car) Driver was
20c TIME OF INJURY Month, Day, Year: Hour 9:32 pm — 11-18 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Intersect. 273 & 280
20f (City or town) Fair Hill, (County) Cecil, (State) Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John M. Byers, M.D.
EXAMINER'S NAME (Type): John McByers, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Elkton, Md.
22 DATE SIGNED: 11-20-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11/22/67
23c NAME OF CEMETERY OR CREMATORY: Immaculate Conception
23d LOCATION (City or Town) Cherry Hill, (County) (State) Md.

24 FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a RECD BY REGISTRAR — DATE: NOV 27 1967
25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15262 15266

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 8 mos 3 days

2 USUAL RESIDENCE (Where deceased lived, if inst tution Residence before adm ssion)
a. STATE: Maryland
b. COUNTY: 17
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital
d. STREET ADDRESS: Rt # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ARTHUR Middle SHERMAN Last DAVIS

4. DATE OF DEATH: Month November Day 6 Year 1967

5 SEX: Male
6 COLOR OR RACE: Negro
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3-25-00
9 AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Clarksburg, Md.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Cornelius (D)
14. MOTHER'S MAIDEN NAME: Alice Green (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 219-56-6786
17 INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of the prostate — INTERVAL BETWEEN ONSET AND DEATH
177X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 8, 1967, to Nov. 6, 1967 that I last saw the deceased on 19 and that death occurred at 5:55 am, from causes and on the date stated above

22a. SIGNATURE: Edgar E. Folk III M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 11-6-67
22c PHYSICIAN'S NAME (Type): EDGAR E. FOLK III, M.D.
22d ADDRESS: VA Hospital, Perry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 11/9/67
23c NAME OF CEMETERY OR CREMATORY: JOHN WESLEY CEMETERY
23d LOCATION (City or Town) (County) (State): CLARKSBURG, MONTG. MD.

24 FUNERAL DIRECTOR: Robert Snowden Funeral Home
ADDRESS: Rockville, Md. 246 N. Wash. St.
MSA. RECD BY REGISTRAR DATE: NOV 10 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15263

CERTIFICATE OF DEATH

15267

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d STREET ADDRESS: 1943 Penrose Ave.,
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: J. — Last: Dean
4 DATE OF DEATH: Month: November — Day: 25 — Year: 1967
5 SEX: Male
6 COLOR OR RACE: Negro
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 10 6 26
9 AGE (In years last birthday): 41 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: WILLIAM DEAN
14 MOTHER'S MAIDEN NAME: HATTIE MIIS
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II
16 SOCIAL SECURITY NO.: 220-12-69-12
17 INFORMANT: Records — Address: VA Hospital - Perry Point, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 Mo.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Malignant Hypertension — 6 Mo.
DUE TO
(c): Glomerulonephritis — 6 Mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from 10 24 48, 19__, to 11 25 67, 19__, that the deceased was/was not seen by me since 19__, and that death occurred at 2:05p M, from causes and on the date stated above.

22a SIGNATURE: Irina Reus — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 11-25-67
22c PHYSICIAN'S NAME (Type): IRINA REUS, M.D.
22d ADDRESS: VA Hospital - Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b DATE THEREOF: 11 26 67
23c NAME OF CEMETERY OR CREMATORY: Baltimore, Nat. Cemetery
23d LOCATION (City or Town) (County) (State): Baltimore, Md.
24 FUNERAL DIRECTOR ADDRESS: MORTON & DYETT 1701 Luarens St. Balto.,Md
25a. RECD BY REGISTRAR DATE: NOV 27 1967
25b REGISTRAR'S SIGNATURE: Wilmalee Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15264 15268

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo RURAL
c. LENGTH OF STAY IN 1b: Life
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Middle First

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo RURAL
d STREET ADDRESS
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ROGER — Middle JAMES — Last ECKARD
4 DATE OF DEATH: Month November — Day 18, — Year 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Oct.16,1940
9 AGE (In years last birthday): 27 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Model Maker
10b KIND OF BUSINESS OR INDUSTRY: U.S.Gov't
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.
13 FATHER'S NAME: James Henry Eckard
14 MOTHER'S MAIDEN NAME: Edna Jones
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO
17 INFORMANT — Address: Mrs. Roger Eckard, Conowingo, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple Injuries — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Pilot in airplane crash
20c TIME OF INJURY Month Day, Year: Hour UNK p.m. 11/18 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Woods
20f. (City or town) (County) (State): Conowingo Cecil Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D. — M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town or county)
22. DATE SIGNED: 11/19/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov.21,1967
23c NAME OF CEMETERY OR CREMATORY: Conowingo Cemetery
23d LOCATION (City or Town) (County) (State): Conowingo Cecil Md.
24a FUNERAL DIRECTOR: H.E. McMullen Funeral Home — Dir.-Tyson — ADDRESS: 200 Cherry St. Rising Sun, Md.
25a. REC'D BY REGISTRAR DATE: NOV 22 1967
25b REGISTRAR'S SIGNATURE: Florence Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15265

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5269

1 PLACE OF DEATH
a. COUNTY: CECIL COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Ohio
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centerburg
d. STREET ADDRESS: R. D. 2, Centerburg, Ohio
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First JOHN — Middle ROOSEVELT — Last ELKINS

4 DATE OF DEATH: Month November — Day 29 — Year 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8 DATE OF BIRTH: May 10, 1905

9 AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Monteville Elkins

14. MOTHER'S MAIDEN NAME: Rosa Boyd

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: 225-05-6554

17. INFORMANT — Address: Mrs. Lucy Elkins, Elkton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.):

20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d INJURY OCCURRED While at work ☐ — Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

22 DATE SIGNED: November 29, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 12/2/67

23c NAME OF CEMETERY OR CREMATORY: Davis Cemetery

23d LOCATION (City or Town) (County) (State): Tazewell Co. Va.

24 FUNERAL DIRECTOR AND ADDRESS: Ralph E. Hicks
Hicks Home for Funerals, Elkton, Md.

25a REC'D BY REGISTRAR DATE: DEC 6 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15266 — 15270

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY: CECIL — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON c. LENGTH OF STAY IN 1b: 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MD — b. COUNTY: CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHERRY HILL d. STREET ADDRESS: RD #4 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
LOUISE	PAGE	FITZWATER	11	8	1967

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
F	W		9-29-19	48 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	WISE CO. VA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ALBERT F. PAGE	CORA D. DAVIS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT	Address
NO		CLIFFORD R. FITZWATER	CHERRY HILL MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Respiratory Arrest — INTERVAL BETWEEN ONSET AND DEATH: Min

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Liver Failure — 4 days

~~DUE TO~~

(c): Thrombosis Hepatic artery — 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from June, 1960 to Nov 8, 1967, that (I) (we) last saw the deceased alive on Nov 8, 1967, and that death occurred at 12:55 PM, from causes and on the date stated above.

22a SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Joseph S. Lanza					11-9-67

22c PHYSICIAN'S NAME (Type)	22d. ADDRESS
JOSEPH S. LANZA	ELKTON, MD

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	11-11-67	CHERRY HILL METH.	CHERRY HILL CECIL MD.

24. FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Robert Good RIPPIN FUNERAL HOME	ELKTON, MD.	NOV 14 1967	

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15267 — 15271

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 2 weeks
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   d. STREET ADDRESS: R.D. 5 Box 170
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alfred — Middle: M. — Last: Foote

4. DATE OF DEATH: Month: Nov. — Day: 12, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 13, 1898

9. AGE (In years last birthday): 69 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Carpenter

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 222-07-0632-A

17. INFORMANT: Mrs. Sarah R. Foote, Elkton, Md. — Address: R.D. 5 Box 170

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: Acute
DUE TO (b): Thrombophlebitis, (L) Femoral vein — 1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Peripheral obliterative Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/5/67, 19..., to 11/12, 19 67 that (I) (we) last saw the deceased alive on 11/12/67 19..., and that death occurred at 4:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John A. Fischer M.D.
22c. PHYSICIAN'S NAME (Type): John A. Fischer.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: ELKTON, Md
22b. DATE SIGNED: 11/17/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/15/67
23c. NAME OF CEMETERY OR CREMATORY: Sharps Cemetery
23d. LOCATION (City, town or county) (State): Fair Hill, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ralph E. Hicks — Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: NOV 27 1967
25b. REGISTRAR'S SIGNATURE: Stanley Judge

VR A1S (4)
20M 5-63

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15268

CERTIFICATE OF DEATH

15773

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN b: 5 Mo.14 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital, Perry Point, Md.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Penna — b. COUNTY: Phila.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia
d. STREET ADDRESS: 2006 W Spencer Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First EDWARD — Middle — Last HALL

4 DATE OF DEATH: Month November — Day 23, — Year 19 67

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH: 4-8-92

9 AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY: ---------

11 BIRTHPLACE (County & State, or foreign country): South Carolina

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS HALL (deceased)

14. MOTHER'S MAIDEN NAME: Diana Broom (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I

16 SOCIAL SECURITY NO.: 167-18-7112

17 INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchopneumonia w/pulmonary infarct, left upper lobe — INTERVAL BETWEEN ONSET AND DEATH: 4-8 days
4200
DUE TO (b): Congestive heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Arteriosclerotic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (X) (this hospital) attended the deceased from June 9, , 19 67, to Nov. 23, , 19 67, ~~I saw the deceased alive on~~ ~~and~~ that death occurred at 5:48 P.M., from causes and on the date stated above

22a SIGNATURE: A. L. Mooney — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS. ☐

22b DATE SIGNED: 11-24-67

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.

22d. ADDRESS: VAH, Perry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11/28/67

23c NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery Baltimore, Md.

23d LOCATION (City or Town) (County) (State)

24 FUNERAL DIRECTOR: SLADE Funeral Home — ADDRESS: 1747 N. 16th St Phila Pa.

25a REC'D BY REGISTRAR DATE: NOV 28 1967

25b REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15269 — 15874

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Elkton
c LENGTH OF STAY IN 1b: 5 yrs.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 311 King St.

2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a STATE: Md. — b COUNTY: Cecil
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Elkton
d STREET ADDRESS: 311 King St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Albert — Middle: Kelly — Last: Halsey
4 DATE OF DEATH: Month: 11 — Day: 22 — Year: 1967

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 2-10-87
9 AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Farmer
10b KIND OF BUSINESS OR INDUSTRY: Farming
11 BIRTHPLACE (State or foreign country): West Va.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Unknown
14 MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service): ~~Yes~~ No ~~World War I~~
16 SOCIAL SECURITY NO: 219-36-0715
17 INFORMANT — Address: Mrs. Alberta Halsey, 311 King St, Elkton, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Unk.
4221
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John M. Byers, M.D.
EXAMINER'S NAME (Type): John M. Byers, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Elkton, Md.
22. DATE SIGNED: 11-22-67

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 11-26-67
23c NAME OF CEMETERY OR CREMATORY: Brookview Cem
23d LOCATION (City or Town) (County, State): Rising Sun Cecil Md.
24 FUNERAL DIRECTOR: H. McMullen — ADDRESS: Rising Sun Md
25a RECD BY REGISTRAR DATE: NOV 27 1967
25b REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15275 — 15275

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4) 20M S-63

1. **PLACE OF DEATH** — a. COUNTY: Cecil — b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Elkton — c. LENGTH OF STAY IN 1b: MARYLAND — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Cecil — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton — d. STREET ADDRESS: Elkmore, R.D. 1 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Harry — Middle: G. — Last: Heath, SR.

4. **DATE OF DEATH**: Month: November — Day: 22, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 12, 1901

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: B. & O Railroad

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William C. Heath, Sr.

14. MOTHER'S MAIDEN NAME: Margaret Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service): No

16. SOCIAL SECURITY NO.: 213-05-3997

17. INFORMANT: Mrs. Charlotte P. Heath, Address: R.D. 1 Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) OCCLUSION ANTERIOR DESCENDING

DUE TO

(c) CORONARY ATTACK

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ADENOCARCINOMA SIGMOID COLON - RESECTED

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/18, 1967 to 11/22, 1967 that (I) (☒) last saw the deceased alive on 11/22/67, 19..., and that death occurred at .. .. .M. from the causes and on the date stated above.

22a. SIGNATURE: Robert L. Gray M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11/24/67

22c. PHYSICIAN'S NAME (Type): Robert L. Gray — 22d. ADDRESS: Elkton Medical Park, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 11/25/67 — 23c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Meth. Cemetery — 23d. LOCATION (City, town or county) (State): Cherry Hill, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: NOV 27 1967 — 25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15271

CERTIFICATE OF DEATH

15276

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 69 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: P.I.T
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Marsh
d. STREET ADDRESS: Ebenezer Road 21162
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle Lewis Last HERMAN
4. DATE OF DEATH: Month November Day 21 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-7-94
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Chemical Plant
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Herman (D)
14. MOTHER'S MAIDEN NAME: Anna Toephner (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO: 220-20-7429
17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease w/calcific aortic stenosis, severe
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obstructive pulmonary emphysema
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that XX (this hospital) attended the deceased from Aug. 23, 1967, to Nov. 21, 19 67 ~~saw the deceased alive on~~, and that death occurred at 1:45 ~~a.m.~~ p.m. from causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11-22-67
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.
22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-24-1967
23c. NAME OF CEMETERY OR CREMATORY: Cokesbury Cemetery
23d. LOCATION (City or Town) (County) (State): Abbingdon, Md.

24. FUNERAL DIRECTOR: Lassahn Funeral Home ADDRESS 7401 Belair Rd
Lassahn Funeral Home, Baltimore, MD

25a. REC'D BY REGISTRAR DATE NOV 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15277

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Church Street

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth; Middle: C.; Last: Johnson
4. DATE OF DEATH: Month: November; Day: 2; Year: 1967
5. SEX: Female
6. COLOR OR RACE: Cau.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 8, 1921
9. AGE (In years last birthday): 46 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bank Teller
10b. KIND OF BUSINESS OR INDUSTRY: Citizen Nat. Bank
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James A. Carson
14. MOTHER'S MAIDEN NAME: Millicent Craig
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO: 214-16-9624
17. INFORMANT: Paul W. Johnson Sr, Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Ca of breast.
170X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 1 yr

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept, 1966 to Nov 67, that (I) (we) last saw the deceased alive on 11/2/67 1967, and that death occurred at 7a M, from causes and on the date stated above

22a. SIGNATURE: John D. Yun
M.D. ATTENDING PHYS ☐ MED DIRECTOR ☑ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): JOHN D. YUN
22d. ADDRESS: Havre de Grace Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov 4, 1967
23c. NAME OF CEMETERY OR CREMATORY: North East Methodist Cem.
23d. LOCATION (City or Town) (County) (State): North East, Maryland

24. FUNERAL DIRECTOR: Lee A. Patterson & Son
ADDRESS: Perryville, Md.

25a. RECD BY REGISTRAR DATE: NOV 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

15273

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15278

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: M. — Last: Kyle

4. DATE OF DEATH: Month: Nov. — Day: 11 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/12/1900

9. AGE (In years last birthday): 67 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Cecil County, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Custard J. Brown

14. MOTHER'S MAIDEN NAME: Alice Booze

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: John Kyle — Address: Colora, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocard. Infarct — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
DUE TO (b): Hypertension. CVD — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Diabetes Mellitus — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-23, 1967, to 11-11, 1967, that (I) (we) last saw the deceased alive on 10-13, 1967, and that death occurred at 1:45 PM, from causes and on the date stated above.

22a. SIGNATURE: G. H. Richards — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/14/67

22c. PHYSICIAN'S NAME (Type): G. H. Richards Jr. MD

22d. ADDRESS: Port Deposit Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/14/67

23c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.

23d. LOCATION (City or Town) (County) (State): Colora, Cecil Md.

24. FUNERAL DIRECTOR: Lemon E. Mullen

ADDRESS: Rising Sun, Md

25a. REC'D BY REGISTRAR DATE: NOV 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15274

CERTIFICATE OF DEATH

15279

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: 54 23 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VAH., Perry Point, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 315 Hall Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle Coleman Last LEFTWICH

4. DATE OF DEATH: Month November Day 25 Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-8-14
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civilian Gunner
10b. KIND OF BUSINESS OR INDUSTRY: Army
11. BIRTHPLACE (County & State, or foreign country): Marion, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GRAVILLE LEFTWICH (Deceased)
14. MOTHER'S MAIDEN NAME: MARGARET BRAGG (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 215-12-4303
17. INFORMANT (Address): VA Hospital records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic pyelonephritis with uremia — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Diabetes mellitus — Years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X (this hospital) attended the deceased from 10-2- , 19 67 , to 11-25- , 19 67 , [illegible] and that death occurred at 9:30 PM from causes and on the date stated above.

22a. SIGNATURE: Joaquin R. Garcia M.D. — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 26 Nov 67
22c. PHYSICIAN'S NAME (Type): Joaquin R. Garcia M.D.
22d. ADDRESS: VAH Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial / Removal
23b. DATE THEREOF: 11-28-67
23c. NAME OF CEMETERY OR CREMATORY: Unk. Harford Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Aldino, Harford Co., Maryland

24. FUNERAL DIRECTOR: FOSTER FUNERAL HOME,
ADDRESS: W. Broadway & Williams Sts. Bel Air, Maryland 21014
25a. RECEIVED BY REGISTRAR (DATE): NOV 29 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15975

CERTIFICATE OF DEATH

15280

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: 7 mo. 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VAH Perry Point, Md.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 721 Jefferson St. N.E., Wash. D.C.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

27

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Theodore	R.	Mikell	Nov.	23	19 67

5 SEX	6. COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Male	Negro		1-19-26	41 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
mathematician	Map svc of U.S. Army	South Carolina	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Mikell	Rosette Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
Yes WW 2	251 22 2986	VA Hospital records Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	BRONCHO-PNEUMONIA Acute Edema & Atelectasis	
DUE TO	of both lower lobes of lungs.	2 hrs - 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO (c)		

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-12, 1967, to 11-23, 19 67 ~~that (I) (we) last saw the deceased alive on xxxxxxxxxxxxxx~~ and that death occurred at 6:50 A.M., from causes and on the date stated above.

22a. SIGNATURE M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
	11-24-67

22c PHYSICIAN'S NAME (Type)	22d ADDRESS
Thomas P. Thompson THOMAS P. THOMPSON, M.D.	VAH, Perry Point, Md.

23a BURIAL/CREMATION/REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY ~~OR CREMATORY~~	23d LOCATION (City or Town) (County) (State)
	11-27-1967	Culpeper Nat. Cemetery	Culpeper, Va.

24 FUNERAL DIRECTOR & ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
C. C. Wagstaff Latney Funeral Home, 3831 Georgia Ave., NW Wash., DC	NOV 27 1967	Deputy Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5276 — 15081

1 PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 1 HR.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Delaware — b. COUNTY: NEW CASTLE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Castle - Chelsea Estates
d. STREET ADDRESS: 40 Paul Road
S RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First RALPH — Middle ~~HUDSON~~ HUDSON — Last NEEL III
4 DATE OF DEATH: Month November — Day 12, — Year 1967

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9-11-50
9 AGE (In years last birthday): 17 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT
10b KIND OF BUSINESS OR INDUSTRY: SCHOOL
11 BIRTHPLACE (State or foreign country): DEL.
12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: RALPH H. NEEL, JR.
14. MOTHER'S MAIDEN NAME: JEAN M. STONE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16 SOCIAL SECURITY NO: —
17 INFORMANT: Address: RALPH H. NEEL, JR. NEWCASTLE, DEL

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrocranial injuries
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Working underneath auto when car jack slipped
20c TIME OF INJURY Month, Day, Year: Hour 1:30 p.m. — 11-12 — 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Dragstrip
20f (City or town) (County) (State): Cecil Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate, M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
22. DATE SIGNED: November 13, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 11-16-67
23c NAME OF CEMETERY OR CREMATORY: BRACELAWN CEMETERY
23d LOCATION (City or Town) NEW CASTLE (County) WILMINGTON (State) DEL

24 FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS: Robert Todd ELKTON, MD.
25a REC'D BY REGISTRAR: DATE NOV 15 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15277

CERTIFICATE OF DEATH

15282

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point,
c. LENGTH OF STAY IN 1b: 364 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: FLORIDA
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orlando
d. STREET ADDRESS: 1217½ South Orange Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FENTON — Middle: L. — Last: NICHOLS

4. DATE OF DEATH: Month: November — Day: 13 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-9-92
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Special investigator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Whitefield Co., Georgia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Maurice Fenton (D)
14. MOTHER'S MAIDEN NAME: Eliza James (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I
16. SOCIAL SECURITY NO: 236-50-6710
17. INFORMANT: VA Hospital Records, Perry Point, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Empyema, Lt. Lung — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Bronchopneumonia, Bilateral
DUE TO
(c): Chronic Pulmonary emphysema with Bronchiectasis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis of Cornary Arteries
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Nov. 14, 1966 to Nov. 13, 1967 xxxxxxxxxx saw the deceased alive on xxxxxxxxxxxxxxx19xxxx and that death occurred at 9:30 am, from causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 11 13 67
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.
22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 11-14-67
23c. NAME OF CEMETERY OR CREMATORY: Winchester Nat. Cemetery
23d. LOCATION (City or Town): Winchester (County): (State): Va.
24. FUNERAL DIRECTOR: Patterson Funeral Home
ADDRESS: Perryville, Md.
25a. REC'D BY REGISTRAR DATE: NOV 20 1967
25b. REGISTRAR'S SIGNATURE: Witness Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

15278

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15283

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: New York — b. COUNTY: C

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point

c. LENGTH OF STAY IN 1b: 124 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

d. STREET ADDRESS: 2821 Avenue I.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARIE — Middle I. — Last O'CONNOR

4 DATE OF DEATH: Month November — Day 8 — Year 1967

5 SEX: Female

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 8-20-06

9 AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): Renovo, Pa.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: David J. O'Connor (D)

14 MOTHER'S MAIDEN NAME: Katherine Coughlin (L)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): 10-1-42 to 10-31-62

16 SOCIAL SECURITY NO: 137-32-2047

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Bronchopneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Brain Tumor (Glioma), Lt. Frontal Lobe — 4-6 months

DUE TO

(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)

20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I (this hospital) attended the deceased from July 7, 1967, to Nov. 8, 1967 that I (this) last saw the deceased alive on [illegible] and that death occurred at 10:00 am from causes and on the date stated above.

22a SIGNATURE: A. L. Mooney M.D. — ATTENDING PHYS ☐ — MED DIRECTOR ☐ — STAFF PHYS ☒

22b DATE SIGNED: 11 8 67

22c PHYSICIAN'S NAME (Type): A. L. Mooney, M.D.

22d ADDRESS: VAH, Perry Point, Md.

23a BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Nov. 13, 1967

23c NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: Jack O. Mccubbin ADDRESS: 3524 Columbia Pike — MURPHY FUNERAL HOME - Arlington, Va.

25a REC'D BY REGISTRAR DATE: NOV 17 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15279

CERTIFICATE OF DEATH

15234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: R.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lloyd — Middle: Richard — Last: Pennington
4. DATE OF DEATH: Month: Nov. — Day: 1 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 7, 1907
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trim Repairman
10b. KIND OF BUSINESS OR INDUSTRY: Chrysler Corp.
11. BIRTHPLACE (County & State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Herbert V. Pennington
14. MOTHER'S MAIDEN NAME: Elizabeth T. Steininger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 075-07-8432
17. INFORMANT — Address: Mrs. Stella E. Lynch, Lewistown, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia & Peritonitis — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Perforated Bowel (Small) — 4-8 days
DUE TO (c): Salmonella typhi Muri

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/22, 1967, to 11/1, 1967 that (I) (we) last saw the deceased alive on 11/1 1967, and that death occurred at 10:40 M, from causes and on the date stated above.

22a. SIGNATURE: I. Randall Ross — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/3/67
22c. PHYSICIAN'S NAME (Type): I. Randall Ross
22d. ADDRESS: Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/5/67
23c. NAME OF CEMETERY OR CREMATORY: McClure Union Cemetery
23d. LOCATION (City or Town) (County) (State): McClure, Penna.

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a. RECD BY REGISTRAR — DATE: NOV 6 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

152-0

CERTIFICATE OF DEATH

15285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 2 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1. PLACE OF DEATH — a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CALVERT
c. LENGTH OF STAY IN 1b: 6 Mo,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CALVERT NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RISING SUN 07
d. STREET ADDRESS: NORTH @ QUEEN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANN — Middle K. — Last ROBERSON

4. DATE OF DEATH: Month NOV. — Day 28 — Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCT 27, 1881
9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL M. KIRK
14. MOTHER'S MAIDEN NAME: VICTORIA PAXSON BILES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
16. SOCIAL SECURITY NO.: 218-32-1516-D
17. INFORMANT — Address: MRS. ANN R. WEBER, ARLINGTON, VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY — IMMEDIATE CAUSE (a): Chronic Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
I221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c): ___

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 19 67 to November 19 67 that (I) (we) last saw the deceased alive on Nov 28 1967, and that death occurred at 1 20 PM, from causes and on the date stated above.

22a. SIGNATURE: Ernest W. Leiter M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov 28, 1967
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/1/67
23c. NAME OF CEMETERY OR CREMATORY: BROOKVIEW CEMETARY
23d. LOCATION (City or Town) (County) (State): RISING SUN, CECIL, MD.

24. FUNERAL DIRECTOR: RALPH M. REED — Ralph M. Reed — ADDRESS: RISING SUN, MD

25a. REC'D BY REGISTRAR — DATE: DEC 1 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ____. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15281

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rural, Conowingo
c LENGTH OF STAY IN 1b: 1 hr.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt. 222

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Pennsylvania
b COUNTY: Lancaster
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Peach Bottom
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOSEPH; Middle FRED; Last SEXTON

4 DATE OF DEATH: Month November; Day 18; Year 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: May 16 1929

9 AGE (In years last birthday): 38 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronics Tech.

10b KIND OF BUSINESS OR INDUSTRY: Civil Service

11 BIRTHPLACE (State or foreign country): North Carolina

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: C. W. Sexton

14 MOTHER'S MAIDEN NAME: Bessie Miller

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: Dorothy M. Sexton
Address: Peach Botton Pa.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Multiple Injuries
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Passenger in airplane crash

20c TIME OF INJURY Hour: UNK pm; Month, Day, Year: 11/18/67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Woods

20f (City or town): Cecil (County): Md. (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):

22. DATE SIGNED: 11/18/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11-21-67

23c NAME OF CEMETERY OR CREMATORY: Darlington Cemetery

23d LOCATION (City or Town): Darlington (County): Harford (State): Md.

24 FUNERAL DIRECTOR: Grant Funeral Home
ADDRESS: Box 22 North East, Md.

25a REC'D BY REGISTRAR DATE: NOV 21 1967

25b REGISTRAR'S SIGNATURE: [signature]

1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VSM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (Rev) 6M 1/67

15282

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15087

PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Conowingo
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt. 222

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Lancaster
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Peach Bottom
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: Lois — Last: SEXTON
4. DATE OF DEATH: Month: November — Day: 18, — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 13, 1959
9. AGE (In years last birthday): 8 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: J. Fred Sexton
14. MOTHER'S MAIDEN NAME: Dorothy M. Carter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Dorothy M. Sexton — Address: Peach Bottom, Pa.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Multiple Injuries
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Passenger in airplace crash
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. UNK — 11/18/ 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Woods
20f. (City or town) (County) (State): Cecil, Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED. EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
22. DATE SIGNED: 11/18/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-21-67
23c. NAME OF CEMETERY OR CREMATORY: Darlington Cemetery
23d. LOCATION (City or Town) (County) (State): Darlington Harford Md.

24. FUNERAL DIRECTOR: Grant Funeral Home
ADDRESS: Box 22 North East, Md.
25a. REC'D BY REGISTRAR DATE: NOV 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15283 — 15238

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: MARYLAND — 17 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: Box 112 R.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Paul — Last: Smith, Sr.

4. DATE OF DEATH: Month: Nov. — Day: 25, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Apr. 12, 1900

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: J.F.K. Hwy.

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Marvin Smith

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 235-07-0140-A

17. INFORMANT: Harold C. Smith, Elkton, Md. — Address: R.D.5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis
DUE TO (b): arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/9, 1967 to 11/25, 1967 that (I) (we) last saw the deceased alive on 11/25 1967, and that death occurred at 3 P.M. from the causes and on the date stated above

22a. SIGNATURE: I. R Ross M.D.
22c. PHYSICIAN'S NAME (Type): I. R. Ross, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/28/67
22d. ADDRESS: Elkton, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/28/67
23c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
23d. LOCATION (City, town or county) (State): Elkton, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ralph E. Hicks — Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: DEC 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15284 15289

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c LENGTH OF STAY IN 1b: 65 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: District of Columbia
b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d STREET ADDRESS: 380 55th Street, NE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOHN Middle HENRY Last STROMAN

4 DATE OF DEATH: Month November Day 2 Year 19 67

5 SEX: Male

6. COLOR OR RACE: Negro

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-8-25

9 AGE (In years last birthday): 42 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): Springfield, S. Carolina

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Otis Stroman (D)

14 MOTHER'S MAIDEN NAME: Maude Corbitt (D)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II

16 SOCIAL SECURITY NO: 248-30-1053

17 INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Nephrosclerosis with uremia
446 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 30, 1967, to Nov. 2, 1967, that (I) (we) last saw the deceased alive on ~~xxxxxxxxxxxxxxxx~~, 19~~xxx~~, and that death occurred at 10:45 a.m. from causes and on the date stated above.

22a. SIGNATURE: Edgar E. Folk III M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: 11-3-67

22c PHYSICIAN'S NAME (Type): EDGAR E. FOLK III, M.D.

22d ADDRESS: VA Hospital, Rerry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11/6/67

23c NAME OF CEMETERY OR CREMATORY: Lincoln Memorial

23d LOCATION (City or Town) (County) (State): Suitland, Md.

24. FUNERAL DIRECTOR: Stewart Funeral Home ADDRESS: Wash., DC

Stewart Funeral Home, 40001 Benning Road, NE

25a. REC'D BY REGISTRAR DATE: NOV 20 1967

25b REGISTRAR'S SIGNATURE: Grimsley Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15285

CERTIFICATE OF DEATH

15541

1 PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: 313 ELKTON BLVD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First RUDOLPH — Middle YORKE — Last TAGGART SR

4 DATE OF DEATH: Month NOVEMBER — Day 4 — Year 1967

5 SEX: MALE

6. COLOR OR RACE: WHITE

7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: JUNE 30, 1897

9 AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF EMP.

10b KIND OF BUSINESS OR INDUSTRY: LAUNDRY

11 BIRTHPLACE (County & State, or foreign country): ELKTON, Md

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD F. TAGGART

14 MOTHER'S MAIDEN NAME: AIYNA RUDULPH

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW I & WW II

16 SOCIAL SECURITY NO: 160-24-3706

17 INFORMANT: MRS. MARY L. TAGGART — Address: ELKTON, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): STROKE — INTERVAL BETWEEN ONSET AND DEATH: 36 Hours
451 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): RUPTURED ABDOMINAL ANUERISH — 36 HOURS
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY, 1936, to NOV. 4, 1967 that (I) (we) last saw the deceased alive on NOV 4 1967, and that death occurred at 4:40 P.M., from causes and on the date stated above

22a. SIGNATURE: Henry V. Davis — M.D — ATTENDING PHYS. ☒ — MED DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 11/5/67

22c. PHYSICIAN'S NAME (Type): HENRY V. DAVIS MD

22d. ADDRESS: CHESAPEAKE CITY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: NOV. 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: GILPIN MANOR MEM. PK.

23d. LOCATION (City or Town) (County) (State): ELKTON CECIL Md.

24 FUNERAL DIRECTOR: W. H. PIPPIN FUNERAL HOME — ADDRESS: ELKTON Md.

25a. RECD BY REGISTRAR DATE: NOV 8 1967

25b. REGISTRAR'S SIGNATURE: Juliantes Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15285 15291

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 5 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital of Cecil County

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: 102 West Beech St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARGARET — Middle: NAOMI — Last: TAYLOR

4. DATE OF DEATH: Month: Nov. — Day: 4 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 3, 1903
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Cecil Co. Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert H. Sipps
14. MOTHER'S MAIDEN NAME: Florence Kline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Virginia Slonecker — Address: 100 W. Beech St. North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 10, 1967, to Nov. 4, 1967, that (I) (we) last saw the deceased alive on Nov. 4 1967, and that death occurred at 10 PM, from the causes and on the date stated above.

22a. SIGNATURE: Jay S. Barnhart Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov. 6, 1967
22c. PHYSICIAN'S NAME (Type): Jay S. Barnhart Jr.
22d. ADDRESS: 4 Mauldin Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-8-67
23c. NAME OF CEMETERY OR CREMATORY: North East Methodist
23d. LOCATION (City, town or county) (State): North East Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — Paul R. Crouch
ADDRESS: Box 22 North East, Md.
25a. REC'D BY REGISTRAR DATE: NOV 8 1967
25b. REGISTRAR'S SIGNATURE: Wilmer Griggs

VR A15 (4)
15M 4-64

4 . 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15287

CERTIFICATE OF DEATH

15992

1 PLACE OF DEATH a. COUNTY: Cecil MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville

c. LENGTH OF STAY IN 1b: 7 Mo 13 Days

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VAH., Perry Point, Md. 27

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: — V

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3

d STREET ADDRESS: 3108 Glenmore Avenue

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: HUGH Middle: H Last: TRADER Jr

4. DATE OF DEATH Month: November Day: 26 Year: 1967

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 8-1-11

9 AGE (In years last birthday): 56 yrs | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sports Writer

10b KIND OF BUSINESS OR INDUSTRY: Newspaper

11 BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HUGH H. TRADER (Deceased)

14. MOTHER'S MAIDEN NAME: MARGARET MELVIN (Deceased)

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 216-10-8383

17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, aspiration type

334X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, generalized

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)

20f (City or town) (County) (State)

21 I certify that ~~XX~~ (this hospital) attended the deceased from 4-13-67, 19__, to 11-26, 1967, ~~xxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx~~ and that death occurred at 7:30PM, from causes and on the date stated above.

22a SIGNATURE: A. L. Mooney M.D | ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☒

22b DATE SIGNED: 11-27-67

22c PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.

22d ADDRESS: VAH, Perry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11/30/67

23c NAME OF CEMETERY OR CREMATORY: Moreland Memorial

23d LOCATION (City or Town) (County) (State): Baltimore Md

24. FUNERAL DIRECTOR ADDRESS: Leonard Ruck 5305 Harford Rd Balto. Md.

25a. REC'D BY REGISTRAR DATE: NOV 28 1967

25b REGISTRAR'S SIGNATURE: Thomas Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15283 — 15283

1. PLACE OF DEATH
a. COUNTY: Cecil County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): STATION HOSP., USNTC, Bainbridge, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): USNTC Bainbridge, Md.
d. STREET ADDRESS: Bainbridge Villege
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Glenn — Middle: Robert — Last: TRUPPI, Jr.

4. DATE OF DEATH: Month: November — Day: 19 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 2, 1967

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 2 — Days: 17
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not Applicable

10b. KIND OF BUSINESS OR INDUSTRY: Not Applicable

11. BIRTHPLACE (County & State, or foreign country): Morris County, N.J.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Glenn Robert TRUPPI

14. MOTHER'S MAIDEN NAME: Virginia Faye LANGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: G.L. Truppi, USNTC, Bainbrige Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crib death, etiology unknown
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a): MILD NONSPECIFIC DIARRHEA - 2 days

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from 15 Oct., 1967, to Nov 13, 1967, that (we) last saw the deceased alive on Nov 13 1967, and that death occurred at 10:35 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Victor E. Del Bene M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 19 Nov 1967

22c. PHYSICIAN'S NAME (Type): VICTOR E. DEL BENE, LT MC USNR

22d. ADDRESS: Station Hosp., USNTC, Bainbridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-22-1967

23c. NAME OF CEMETERY OR CREMATORY: Summerset Hills Cemetery

23d. LOCATION (City, town or county) (State): Basking Ridge, N.J.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Lee A. Patterson & Son, Perryville, Md.

25a. REC'D BY REGISTRAR DATE: NOV 24 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M S-63

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15284 — 13284

1 PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON, MD.
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: MD — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: 514 NORTH
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES — Middle: T. — Last: WELDIN

4 DATE OF DEATH: Month: 11 — Day: 11 — Year: 1967

5. SEX: M

6 COLOR OR RACE: W

7 MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8 DATE OF BIRTH: 8-1-86

9 AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET U.S. GOVT.

10b KIND OF BUSINESS OR INDUSTRY: GOVT.

11 BIRTHPLACE (County & State, or foreign country): WILMINGTON, DEL

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES WELDIN

14. MOTHER'S MAIDEN NAME: HANNA BLEST

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): [illegible]

16 SOCIAL SECURITY NO.: 212-22-0903

17 INFORMANT Address: CORNELIA E. WELDIN ELKTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardio Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Coronary thrombosis — [illegible]
DUE TO (c): Arteriosclerosis — [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/1/67, to 11/14/67, that (I) (we) last saw the deceased alive on 11/11/67, and that death occurred at 3:40 P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ROLANDO A. NATERA

22d. ADDRESS: 105 E. MAIN ST. ELKTON, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 11-14-67

23c NAME OF CEMETERY OR CREMATORY: GILPIN MANOR MEM. PK.

23d LOCATION (City or Town) (County) (State): ELKTON CECIL MD.

24. FUNERAL DIRECTOR: RIPPIN FUNERAL HOME — **ADDRESS**: ELKTON MD.

25a REC'D BY REGISTRAR DATE: NOV 14 1967

25b. REGISTRAR'S SIGNATURE: [signature]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15296 15285

PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: District of Columbia b. COUNTY:
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point / c LENGTH OF STAY IN 1b: 7 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital	d. STREET ADDRESS: 19 Q Street, NW / e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: LONNIE Middle: Last: WHITAKER	4 DATE OF DEATH Month: November Day: 9 Year: 1967

5. SEX: Male	6. COLOR OR RACE: Negro	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH: 7-2-92	9 AGE (In years last birthday): 75 yrs	IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b KIND OF BUSINESS OR INDUSTRY:	11 BIRTHPLACE (County & State or foreign country): North Carolina	12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Dorsey Whitaker (D)	14. MOTHER'S MAIDEN NAME: Lulu Hillard (D)

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): WW I	16. SOCIAL SECURITY NO.: 578-66-6105	17. INFORMANT / Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that XX (this hospital) attended the deceased from Nov. 2, 1967, to Nov. 9, 1967, xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx, and that death occurred at 12:30 pm, from causes and on the date stated above

22a SIGNATURE: Edgar E. Folk III M D ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 11-9-67
22c. PHYSICIAN'S NAME (Type): EDGAR E. FOLK III, M.D.
22d ADDRESS: VAH, Perry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): (Burial circled)
23b DATE THEREOF: 11-14-67
23c NAME OF CEMETERY OR CREMATORY: Lincoln Mem
23d LOCATION (City or Town) (County) (State): Suitland Md

24 FUNERAL DIRECTOR: Frazier Funeral Home — ADDRESS: 389 R.I. Ave. NW
Frazier Funeral Home, Washington, DC
25a REC'D BY REGISTRAR DATE: NOV 16 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15291

CERTIFICATE OF DEATH

15296

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: 103 Jethro St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD — Middle ROYAL — Last WYRE

4. DATE OF DEATH: Month Nov. — Day 20 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 14 1903

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Fireworks

11. BIRTHPLACE (County & State, or foreign country): Cecil Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William P. Wyre

14. MOTHER'S MAIDEN NAME: Annie Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-05-6140

17. INFORMANT: Flora E. Wyre — Address: 103 Jethro St. North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Pulmonary Emboli with Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 days
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b): Bilateral Septicemic Thrombophlebitis — 20 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this haspital) attended the deceased from 11/5, 1967, to 11/20, 1967, that (I) (we) last saw the deceased alive an 11/20 1967, and that death accurred at 4:09 P.M, from causes and an the date stated above.

22a. SIGNATURE: Klaus H. Huebner — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/20/67

22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER

22d. ADDRESS: NORTH EAST, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-22-67

23c. NAME OF CEMETERY OR CREMATORY: North East Methodist

23d. LOCATION (City or Town) (County) (State): North East Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — Paul R. Council

ADDRESS: Box 22 North East, Md.

25a. RECD BY REGISTRAR DATE: NOV 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15292

CERTIFICATE OF DEATH

15297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 1yr.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emily — Middle: — Last: Zeh

4. DATE OF DEATH: Month: November — Day: 21 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 31, 1880

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Oaklyn, N.J. — Mrs. Gladys Hoffner, 913 Newton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Chronic Glomerulo nephritis — 1-2 months

DUE TO (c): Generalized Arteriosclerosis — Sev. years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/15, 1967, to 11/21, 1967 that (I) (we) last saw the deceased alive on 11/21 1967, and that death occurred at 10:00 AM, from causes and on the date stated above.

22a. SIGNATURE: Rolando A. Najera M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/21/67

22c. PHYSICIAN'S NAME (Type): Rolando A. Najera

22d. ADDRESS: 105 E. Main St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/24/67

23c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Cemetery

23d. LOCATION (City or Town) (County) (State): Sumerton, Penna.

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: NOV 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66